CHILD AND ADOLESCENT NEEDS AND STRENGTHS (CANS)

COMPREHENSIVE MULTISYSTEM ASSESSMENT

Indiana CANS 0 to 5 Manual

Version 2.3

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Acknowledgements

A large number of individuals have collaborated in the development of the CANS-Comprehensive tool. Along with the CANS versions for developmental disabilities, juvenile justice, and child welfare, this information integration tool is designed to support individual case planning and the planning and evaluation of service systems. The CANS-Comprehensive is an open domain tool for use in service delivery systems that address the mental health of children, adolescents and their families. The copyright is held by the Praed Foundation to ensure that it remains free to use.

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The **Child and Adolescent Needs and Strengths (CANS)** is a multiple purpose information integration tool that is designed to be the output of an assessment process. The purpose of the CANS is to accurately represent the shared vision of the childhood serving system—children and families. As such, completion of the CANS is accomplished in order to allow for the effective communication of this shared vision for use at all levels of the system. Since its primary purpose is communication, the CANS is designed based on communication theory rather than the psychometric theories that have influenced most measurement development. There are six key principles of a communimetric measure that apply to understanding the CANS.

Six Key Principles of the CANS

1. **Items were selected because they are each relevant to service/treatment planning.** An item exists because it might lead you down a different pathway in terms of planning actions.
2. **Each item uses a 4-level rating system that translates into action**. Different action levels exist for needs and strengths. For a description of these action levels please see below.
3. **Rating should describe the child, not the child in services.** If an intervention is present that is masking a need but must stay in place, this should be factored into the rating consideration and would result in a rating of an "actionable" need (i.e. '2' or '3').
4. **Culture and development should be considered prior to establishing the action levels.** Cultural sensitivity involves considering whether cultural factors are influencing the expression of needs and strengths. Ratings should be completed considering the child's developmental and/or chronological age depending on the item. In other words, anger control is not relevant for a very young child but would be for an older preschooler. Alternatively, school achievement should be considered within the framework of expectations based on the child's developmental age.
5. **The ratings are generally "agnostic as to etiology".** In other words this is a descriptive tool; it is about the "what" not the "why". Only one item, Adjustment to Trauma, has any cause-effect judgments.
6. **A 30-day window is used for ratings in order to make sure assessments stay relevant to the child's present circumstances.** However, the action levels can be used to over-ride the 30-day rating period.

History and background of the CANS

The CANS is a multi-purpose tool developed to support care planning and level of care decision-making, to facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of services. The CANS was developed from a communication perspective in order to facilitate the linkage between the assessment process and the design of individualized service plans including the application of evidence-based practices.

The CANS gathers information on children and parents or caregivers' needs and strengths. Strengths are the child's assets: areas life where he or she is doing well or has an interest or ability. Needs are areas where a child requires help or intervention. Care providers use an assessment process to get to know the child and the families with whom they work and to understand their strengths and needs. The CANS helps care providers decide which of a child's needs are the most important to address in a treatment or service planning. The CANS also helps identify strengths, which can be the basis of a treatment or service plan. By working with the child and family during the assessment process and talking together about the CANS, care providers can develop a treatment or service plan that addresses a child's strengths and needs while building strong engagement.

The CANS is made of domains that focus on various areas in a child's life, and each domain is made up of a group of specific items. There are domains that address how the child functions in everyday life, on specific emotional or behavioral concerns, on risk behaviors, on strengths and on skills needed to grow and develop. There is also a section that asks about the family's beliefs and preferences, and a section that asks about general family

concerns. The care provider, along with the child and family as well as other stakeholders give a number action level to each of these items. These action levels help the provider, child and family understand where intensive or immediate action is most needed, and also where a child has assets that could be a major part of the treatment or service plan. The CANS action levels, however, do not tell the whole story of a child's strengths and needs. Each section in the CANS is merely the output of a comprehensive assessment process and is documented alongside narratives where a care provider can provide more information about the child.

History. The Child and Adolescent Needs and Strengths grew out of John Lyons' work in modeling decision-making for psychiatric services. To assess appropriate use of psychiatric hospital and residential treatment services, the childhood Severity of Psychiatric Illness (CSPI) tool was created. This measure assesses those dimensions crucial to good clinical decision-making for intensive mental health service interventions and was the foundation of the CANS. The CSPI tool demonstrated its utility in informing decision-making for residential treatment (Lyons, Mintzer, Kisiel, & Shallcross, 1998) and for quality improvement in crisis assessment services (Lyons, Kisiel, Dulcan, Chesler & Cohen, 1997; Leon, Uziel-Miller, Lyons, Tracy, 1998). The strength of this measurement approach has been that it is face valid and easy to use, yet provides comprehensive information regarding clinical status.

The CANS assessment builds upon the methodological approach of the CSPI, but expands the assessment to include a broader conceptualization of needs and an assessment of strengths – both of the child and the caregiver, looking primarily at the 30-day period prior to completion of the CANS. It is a tool developed with the primary objective of supporting decision making at all levels of care: children and families, programs and agencies, child serving systems. It provides for a structured communication and critical thinking about children and their context. The CANS is designed for use either as a prospective assessment tool for decision support and recovery planning or as a retrospective quality improvement device demonstrating an individual child's progress. It can also be used as a communication tool that provides a common language for all child-serving entities to discuss the child's needs and strengths. A review of the case record in light of the CANS assessment tool will provide information as to the appropriateness of the recovery plan and whether individual goals and outcomes are achieved.

Training and periodic certification are required for providers who administer the CANS and their supervisors. Additional training is available for CANS SuperUsers as experts of CANS assessment administration, scoring, and use in the development of service or recovery plans.

Measurement properties

Reliability

Strong evidence from multiple reliability studies indicates that the CANS can be completed reliably by individuals working with children, youth, and families. A number of individuals from different backgrounds have been trained and certified to use the CANS assessment reliably including health and mental health providers, child welfare case workers, probation officers, and family advocates. With approved training, anyone with a bachelor's degree can learn to complete the tool reliably, although some applications or more complex versions of the CANS require a higher educational degree or relevant experience. The average reliability of the CANS is 0.78 with vignettes across a sample of more than 80,000 trainees. The reliability is higher (0.84) with case records, and can be above 0.90 with live cases (Lyons, 2009). The CANS is auditable and audit reliabilities demonstrate that the CANS is reliable at the item level (Anderson et al., 2001). Training and certification with a reliability of at least 0.70 on a test case vignette is required for ethical use. In most jurisdictions, re-certification is annual. A full discussion on the reliability of the CANS assessment is found in Lyons (2009) *Communimetrics: A Communication Theory of Measurement in Human Service Settings*.

Validity

Studies have demonstrated the CANS' validity, or it's the ability to measure and their caregiver's needs and strengths. In a sample of more than 1,700 cases in 15 different program types across New York State, the total scores on the relevant dimensions of the CANS-Mental Health retrospectively distinguished level of care (Lyons, 2004). The CANS assessment has also been used to distinguish needs of children in urban and rural settings (Anderson & Estle, 2001). In numerous jurisdictions, the CANS has been used to predict service utilization and costs, and to evaluate outcomes of clinical interventions and programs (Lyons, 2004; Lyons & Weiner, 2009; Lyons, 2009). Five independent research groups in four states have demonstrated the reliability and validity of decision support algorithms using the CANS (Chor, et al, 2012, 2013, 2014; Cardall, et al, 2016; Epstein, et al, 2015; Israel, et al, 2015, Lardner, 2015).

Rating needs & strengths

The CANS is easy to learn and is well liked by children and families, providers and other partners in the services system because it is easy to understand.

- ★ Basic core items – grouped by domain – are rated for all individuals.
- ★ A rating of 1, 2 or 3 on key core questions triggers extension modules.
- ★ Individual assessment module questions provide additional information in a specific area.

Each CANS rating suggests different pathways for service planning. There are four levels of rating for each item with specific anchored definitions. These item level definitions, however, are designed to translate into the following action levels (separate for needs and strengths):

Basic Design for Rating Needs

Rating	Level of Need	Appropriate Action
0	No evidence of need	No action needed
1	Significant history or possible need that is not interfering with functioning	Watchful waiting/prevention/additional assessment
2	Need interferes with functioning	Action/intervention required
3	Need is dangerous or disabling	Immediate action/Intensive action required

Basic Design for Rating Strengths

Rating	Level of Strength	Appropriate Action
0	Centerpiece strength	Central to planning
1	Strength preset	Useful in planning
2	Identified strength	Build or develop strength
3	No strength identified	Strength creation or identification may be indicated

The rating of 'N/A' for 'not applicable' is available for a few items under specified circumstances (see reference guide descriptions). For those items where the 'N/A' rating is available, the N/A rating should be used only in the rare instances where an item does not apply to that particular child.

To complete the CANS, a CANS trained and certified care coordinator, case worker, clinician, or other care provider, should read the anchor descriptions for each item and then record the appropriate rating on the CANS form (or electronic record). This process should be done collaboratively with the child, family and other stakeholders.

Remember that the item anchor descriptions are examples of circumstances which fit each rating ('0', '1', '2', or '3'). The descriptions, however, are not inclusive and the action level ratings should be the primary rating descriptions considered (see page 6). The rater must consider the basic meaning of each level to determine the appropriate rating on an item for an individual. To support rating the Birth to Five CANS, a glossary, including information about early childhood development (Walton, Moynihan, & Cornett, 2015).

The CANS is an information integration tool, intended to include multiple sources of information (e.g., child and family, referral source, treatment providers, daycare/preschool, and observation by the rater). As a strength-based approach, the CANS supports the belief that children and families have unique talents, skills, and life events, in addition to specific unmet needs. Strength-based approaches to assessment and service or treatment planning focus on collaborating with children and their families to discover individual and family functioning and strengths. Failure to demonstrate a child's skill should first be viewed as an opportunity to learn the skill as opposed to the problem. Focusing on child's strengths instead of weaknesses with their families may result in enhanced motivation and improved performance. Involving the family and child in the rating process and obtaining information (evidence) from multiple sources is necessary and improves the accuracy of the rating. Meaningful use of the CANS and related information as tools (for reaching consensus, planning interventions, monitoring progress, psychoeducation, and supervision) support effective services for children and families.

As a quality improvement activity, a number of settings have utilized a fidelity model approach to look at service/treatment/action planning based on the CANS assessment. A rating of '2' or '3' on a CANS need suggests that this area must be addressed in the service or treatment plan. A rating of a '0' or '1' identifies a strength that can be used for strength-based planning and a '2' or '3' a strength that should be the focus on strength-building activities, when appropriate. It is important to remember that when developing service and treatment plans for healthy children trajectories, balancing the plan to address risk behaviors/needs and protective factors/strengths is key. It has been demonstrated in the literature that strategies designed to develop children's capabilities are a promising means for development, and play a role in reducing risky behaviors.

Finally, the CANS can be used to monitor outcomes. This can be accomplished in two ways. First, CANS items that are initially rated a '2' or '3' are monitored over time to determine the percent of individuals who move to a rating of '0' or '1' (resolved need, built strength). Domain scores can also be generated by averaging or summing items within each of the domains (Behavioral/Emotional Needs, Risk Behaviors, Functioning, etc.). These scores can be compared over the course of treatment. CANS dimension/domain scores have been shown to be valid outcome measures in residential treatment, intensive community treatment, foster care and treatment foster care, community mental health, and juvenile justice programs.
The CANS is an open domain tool that is free for anyone to use with training and certification. There is a community of people who use the various versions of the CANS and share experiences, additional items, and supplementary tools.

How is the CANS Used?

The CANS is used in many ways to transform the lives of children and their families and to improve our programs. Hopefully, this guide will help you to also use the CANS as a multi-purpose tool. What is the CANS?

It is an assessment strategy. When initially meeting clients and their caregivers, this guide can be helpful in ensuring that all the information required is gathered. Most items include "Questions to Consider" which may be useful in when asking about needs and strengths. These are not questions that must be asked, but are available as suggestions. Many clinicians have found this useful to use during initial sessions either in person or over the phone if there are follow up sessions required to get a full picture of needs before treatment or service planning and beginning therapy or other services.

It guides care and treatment/service planning. When an item on the CANS is rated a '2' or '3' ('action needed' or 'immediate action needed') we are indicating not only that it is a serious need for our client, but one that we are going to attempt to work on during the course of our treatment. As such, when you write your treatment plan, you should do your best to address any Needs, Impacts on Functioning, or Risk factors that you rate as a 2 or higher in that document.

It Facilitates Outcomes Measurement. Many users of the CANS and organizations complete the CANS every 6 months to measure change and transformation. We work with children and families and their needs tend to change over time. Needs may change in response to many factors including quality clinical support provided. One way we determine how our supports are helping to alleviate suffering and restore functioning is by re-assessing needs, adjusting treatment or service plans, and tracking change.

It is a Communication Tool. When a client leaves a treatment programs, a closing CANS may be completed to define progress, measure ongoing needs and help us make continuity of care decisions. Doing a closing CANS, much like a discharge summary integrated with CANS ratings, provides a picture of how much progress has been made, and allowing for recommendations for future care which tie to current needs. And finally, it allows for a shared language to talk about our child and creates opportunities for collaboration. It is our hope that this guide will help you to make the most out of the CANS and guide you in filling it out in an accurate way that helps you make good clinical decisions.

CANS: A behavior health care strategy

The CANS is an excellent strategy in addressing children's behavioral health care. As it is meant to be an outcome of an assessment, it can be used to organize and integrate the information gathered from clinical interviews, records reviews, and information from screening tools and other measures.
It is a good idea to know the CANS and use the domains and items to help with your assessment process and information gathering sessions/clinical interviews with the child and family. This will not only help the organization of your interviews, but will make the interview more conversational if you are not reading from a form. A conversation is more likely to give you good information, so have a general idea of the items. The CANS domains can be a good way to think about capturing information. You can start your assessment with any of the sections—Life Domain Functioning or Behavioral/Emotional Needs, Risk Behaviors or Child Strengths, or Caregiver Resources & Needs—this is your judgment call. Sometimes, people need to talk about needs before they can acknowledge strengths. Sometimes, after talking about strengths, then they can better explain the needs. Trust your judgment, and when in doubt, always ask, "We can start by talking about what you feel that you and your child's needs, or we can start by talking about the things that are going well and that you want to build on. Do you have a preference?"

Some people may "take off" on a topic. Being familiar the CANS items can help in having more natural conversations. So, if the family is talking about situations around the child's anger control and then shift into something like---"you know, he only gets angry when he is in Ms. S's room", you can follow that and ask some questions about situational anger, and then explore other daycare/preschool related issues that you know are a part of the School/Preschool/Daycare module. Making the best use of the CANS. Children have families involved in their lives, and their family can be a great asset to their treatment. To increase family involvement and understanding, it is important to talk to them about the assessment process and describe CANS and how it will be used. The description of the CANS should include teaching the child and family about the needs and strengths rating scales, identifying the domains and items, as well as how the actionable items will be used in treatment or serving planning. When possible, have share with the child and family the CANS domains and items (see the CANS Core Item list on page 11) and encourage the family to look over the items prior to your meeting with them. The best time is your decision—you will have a sense of the timing as you work with each family. Families often feel respected as partners when they are prepared for a meeting or a process. A copy of the completed CANS ratings should be reviewed with each family. Encourage families to contact you if they wish to change their answers in any area that they feel needs more or less emphasis.

Listening using the CANS

Listening is the most important skill that you bring to working with the CANS. Everyone has an individual style of listening. The better you are at listening, the better the information you will receive. Some things to keep in mind that make you a better listener and that will give you the best information:

- ★ **Use nonverbal and minimal verbal prompts.** Head nodding, smiling and brief "yes", "and"—things that encourage people to continue
- ★ **Be nonjudgmental and avoid giving person advice.** You may find yourself thinking "if I were this person, I would do X" or "that's just like my situation, and I did "X". But since you are not that person, what you would do is not particularly relevant. Avoid making judgmental statements or telling them what you would do. It's not really about you.
- ★ **Be empathic.** Empathy is being warm and supportive. It is the understanding of another person from their point of reference and acknowledging feelings. You demonstrate empathetic listening when you smile, nod, maintain eye contact. You also demonstrate empathetic listening when you follow the person's lead and acknowledge when something may be difficult, or when something is great. You demonstrate empathy when you summarize information correctly. All of this demonstrates to the child and family that you are with them.
- ★ **Be comfortable with silence.** Some people need a little time to get their thoughts together. Sometimes, they struggle with finding the right words. Maybe they are deciding how they want to respond to a question. If you are concerned that the silence means something else, you can always ask "does that make sense to you"? "Or do you need me to explain that in another way"?
- ★ **Paraphrase and clarify—avoid interpreting.** Interpretation is when you go beyond the information given and infer something—in a person's unconscious motivations, personality, etc. The CANS is not a tool to come up with causes. Instead, it identifies things that need to be acted upon. Rather than talk about causation, focus on paraphrasing and clarifying. Paraphrasing is restating a message very clearly in a different form, using different words. A paraphrase helps you to (1) find out if you really have understood an answer; (2) clarify what was said, sometimes making things clearer; (3) demonstrate empathy. For example, you ask the questions about health, and the person you are talking to gives a long description. You paraphrase by saying "Ok, it sounds like ……is that right? Would you say that is something that you feel needs to be watched, or is help needed?"

★ **Redirect the conversation to parents'/caregivers'/ own feelings and observations.** Often, people will make comments about other people's observations such as "well, my mother thinks that his behavior is really obnoxious." It is important to redirect people to talk about their observations: "so your mother feels that when he does X, that is obnoxious. What do YOU think?" The CANS is a tool to organize all points of observation, but the parent or caregiver's perspective can be the most critical. Once you have the family's perspective, you can then work on organizing and coalescing the other points of view.

★ **Acknowledge Feelings.** People will be talking about difficult things, and it is important to acknowledge that. Simple acknowledgement such as "I hear you saying that it can be difficult when … "demonstrates empathy.

★ **Wrapping it up.** At the end of the assessment, we recommend the use of two open-ended questions. These questions ask if there are any past experiences that people want to share that might be of benefit to planning for their young person, and if there is anything that they would like to add. This is a good time to see if there is anything "left over"—feelings or thoughts that they would like to share with you.

Take time to summarize with the individual and family those areas of strengths and of needs. Help them to get a "total picture" of the individual and family, and offer them the opportunity to change any ratings as you summarize or give them the "total picture".

Take a few minutes to talk about what the next steps will be. Now you have information organized into a framework that moves into the next stage—planning.

So you might close with a statement such as: "OK, now the next step is a "brainstorm" where we take this information that we've organized and start writing a plan—it is now much clearer which needs must be met and what we can build on. So let's start….."

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Basic Structure of the CANS Comprehensive Tool for Youth Birth to 5

The CANS Comprehensive Multisystem Tool expands depending upon the needs of the child and family. Basic core items are rated for all children and unpaid caregivers. Extension modules are triggered by key core questions. Additional questions are required for the decision models to function. (See CANS Comprehensive 0 to 5 Scoring Form.)

Core Items

Life Domain Functioning
Family Functioning
Living Situation
Preschool/Daycare*
Social Functioning
Recreation/Play
Developmental/Intellectual
Motor
Communication
Medical/Physical
Sleep
Relationship Permanence

Child's Strengths
Family Strengths
Extended Family Relationships
Interpersonal
Adaptability
Persistence
Curiosity

Cultural Factors
Language
Cultural Identity
Traditions and Rituals
Cultural Stress
Cultural Differences

Caregiver Needs and Resources
Supervision
Involvement with Care
Knowledge
Empathy for Child
Organization
Social Resources
Residential Stability
Physical
Mental Health
Substance Use
Developmental
Accessibility to Child Care
Family Stress
Safety*
Marital/Partner Violence in the Home
Abuse/Neglect*

Child Behavioral/Emotional Needs
Attachment Difficulties
Regulatory
Failure to Thrive
Depression
Anxiety
Atypical Behaviors
Impulsivity/Hyperactivity
Oppositional
Adjustment to Trauma*

Child Risk Factors
Birth Weight
Pica
Prenatal Care
Labor and Delivery
Substance Exposure
Parent or Sibling Problems
Parental Availability

Child Risk Behaviors
Self Harm
Aggressive Behavior
Social Behavior

CODING DEFINITIONS

LIFE DOMAIN FUNCTIONING

	FAMILY FUNCTIONING ***"Family" ideally should be defined by the child; however, in the absence of this knowledge consider biological and adoptive relatives and their significant others with whom the child has contact as the definition of family. Foster families should only be considered if they have made a significant commitment to the child. For youth involved with child welfare, family refers to the person(s) fulfilling the permanency plan.***
0	No evidence of problems in interaction with family members.
1	Child is doing adequately in relationships with family members although some problems may exist. For example, some family members may have mild problems in their relationships with child including sibling rivalry or under-responsiveness to child needs.
2	Child is having moderate problems with parents, siblings and/or other family members. Frequent arguing, strained interaction with parent, and poor sibling relationships may be observed.
3	Child is having severe problems with parents, siblings, and/or other family members. This would include problems of domestic violence, constant arguing, and aggression with siblings.

	LIVING SITUATION ***This item refers to the functioning of the child within their current living arrangement. When the child is potentially returning to biological parents, this item is rated independent of the Family Functioning item. When the child lives with biological or adoptive parents this item is rated the same as the Family Functioning item. Hospital and shelters do not count as "living situations". If a child is presently in one of these places, rate the previous living situation.***
0	No evidence of problem with functioning in current living environment.
1	Mild problems with functioning in current living situation. Caregivers concerned about child's behavior or needs at home.
2	Moderate to severe problems with functioning in current living situation. Child has difficulties maintaining his/her behavior in this setting creating significant problems for others in the residence. Parents of infants concerned about irritability of infant and ability to care for infant.
3	Profound problems with functioning in current living situation. Child is at immediate risk of being removed from living situation due to his/her behaviors or unmet needs.

	PRESCHOOL/DAYCARE ***This item rates the child's experiences in preschool or day care settings and the child's ability to get his/her needs met in these settings. This item also considers the presence of problems within these environments in terms of attendance, academic achievement, support from the day care or preschool staff to meet the child's needs, and child's behavioral response to these environments.***
0	No evidence of problem with functioning in current preschool or daycare environment.
1	Mild problems with functioning in current preschool or daycare environment.
2	Moderate to severe problems with functioning in current preschool or daycare environment. Child has difficulties maintaining his/her behavior in this setting creating significant problems for others.
3	Profound problems with functioning in current preschool or daycare environment. Child is at immediate risk of being removed from program due to his/her behaviors or unmet needs.

	SOCIAL FUNCTIONING ***This item rates the child's current social and relationship functioning. This includes age appropriate behavior and the ability to make and maintain relationships during the past 30 days. When rating this item, consider the child's level of development.***
0	No evidence of problems in social functioning.
1	Child is having some minor problems in social relationships. Infants may be slow to respond to adults, Toddlers may need support to interact with peers and preschoolers may resist social situations.
2	Child is having some moderate problems with his/her social relationships. Infants may be unresponsive to adults, and unaware of other infants. Toddlers may be aggressive and resist parallel play. Preschoolers may argue excessively with adults and peers and lack ability to play in groups even with adult support.
3	Child is experiencing severe disruptions in his/her social relationships. Infants show no ability to interact in a meaningful manner. Toddlers are excessively withdrawn and unable to relate to familiar adults. Preschoolers show no joy or sustained interaction with peers or adults, and/or aggression may be putting others at risk.

	RECREATION/PLAY ***This item rates the degree to which an infant/child is given opportunities for and participates in age appropriate play. Play should be understood developmentally. When rating this item, you should consider if the child is interested in play and/or whether the child needs adult support while playing. Problems with either solitary or group (e.g. parallel) play could be rated here.***
0	No evidence that infant or child has problems with recreation or play.
1	Child is doing adequately with recreational or play activities although some problems may exist. Infants may not be easily engaged in play. Toddlers and preschoolers may seem uninterested and poorly able to sustain play.
2	Child is having moderate problems with recreational activities. Infants resist play or do not have enough opportunities for play. Toddlers and preschoolers show little enjoyment or interest in activities within or outside the home and can only be engaged in play/recreational activities with ongoing adult interaction and support.
3	Child has no access to or interest in play or recreational activities. Infant spends most of time non interactive. Toddlers and preschoolers even with adult encouragement cannot demonstrate enjoyment or use play to further development.

	DEVELOPMENTAL/INTELLECTUAL ***This item rates the presence of any developmental or Intellectual Disability. It includes Intellectual Developmental Disorder (IDD) and Autism Spectrum Disorders. Rate the item depending on the significance of the disability and the related level of impairment in personal, social, family school, or occupational functioning.***
0	There is no evidence of a developmental delay and/or child has no developmental problem or intellectual disability.
1	Child has some problems with physical immaturity or there are concerns about possible developmental delay. Child may have low IQ, a documented delay, learning disability, or documented borderline intellectual disability, (i.e. FSIQ 70-85). Mild deficits in adaptive functioning are indicated.
2	Child has mild developmental delays (deficits in social functioning, inflexibility of behavior causing functional problems in one or more settings) and/or mild to moderate Intellectual Disability. (If available, FSIQ 55-70.) IDD impacts communication, social functioning, daily living skills, judgment, and/or risk of manipulation by others.
3	Child has severe to profound intellectual disability (FSIQ, if available, less than 55) and/or Autism Spectrum Disorder with marked to profound deficits in adaptive functioning in one or more areas: communication, social participation and independent living across multiple environments.

	MOTOR ***This rating describes the child's fine (e.g. hand grasping and manipulation) and gross (e.g. sitting, standing, walking) motor functioning).***
0	No evidence of fine or gross motor development problems.
1	Child has some indicators that motor skills are challenging and there may be some concern that there is a delay.
2	Child has either fine or gross motor skill delays.
3	Child has significant delays in fine or gross motor development or both. Delay causes impairment in functioning.

	COMMUNICATION ***This rating describes the child's ability to communicate through any medium including all spontaneous vocalizations and articulations. This item refers to learning disabilities involving expressive and/or receptive language. This item does not refer to challenges expressing feelings.***
0	No evidence of communication problems.
1	Child has a history of communication problems but currently is not experiencing problems. An infant may rarely vocalize. A toddler may have very few words and become frustrated with expressing needs. A preschooler may be difficult for others to understand.
2	Child has either receptive or expressive language problems that interfere with functioning. Infants may have trouble interpreting facial gestures or initiate gestures to communicate needs. Toddlers may not follow simple 1-step commands. Preschoolers may be unable to understand simple conversation or carry out 2-3 step commands.
3	Child has serious communication difficulties and is unable to communicate in any way including pointing and grunting.

	MEDICAL/PHSYICAL ***This rating describes both health problems and chronic/acute physical conditions or impediments.***
0	No current need; no need for action or intervention. No evidence that the child has any medical or physical problems, and/or the child is healthy.
1	Identified need requires monitoring, watchful waiting, or preventive activities. Child has mild, transient or well-managed physical or medical problems. These include well-managed chronic conditions like juvenile diabetes or asthma.
2	Action or intervention is required to ensure that the identified need is addressed; need is interfering with child's functioning. Child has serious medical or physical problems that require medical treatment or intervention. Or child has a chronic illness or a physical challenge that requires ongoing medical intervention.
3	Problems are dangerous or disabling; requires immediate and/or intensive action. Child has life-threatening illness or medical/physical condition. Immediate and/or intense action should be taken due to imminent danger to child's safety, health, and/or development.

	SLEEP ***This item is used to describe any problems with sleep, regardless of the cause including difficulties falling asleep or staying asleep as well as sleeping too much. Bedwetting and nightmares should be considered a sleep issue.*** **The child must be 12 months of age or older to rate this item.**
0	No evidence of problems with sleep.
1	Child has some problems with sleep. Toddlers resist sleep and consistently need a great deal of adult support to sleep. Preschoolers may have either a history of poor sleep or continued problems 1-2 nights per week.
2	Child is having problems with sleep. Toddlers and preschoolers may experience difficulty falling asleep, night waking, night terrors or nightmares on a regular basis.
3	Child is experiencing significant sleep problems that result in sleep deprivation. Parents have exhausted numerous strategies for assisting child.

	RELATIONSHIP PERMANENCE ***This rating refers to the stability of significant relationships in the child or youth's life. This likely includes family members but may also include other individuals.***
0	This level indicates a child who has very stable relationships. Family members, friends, and community have been stable for most of child's life and are likely to remain so in the foreseeable future. Child is involved with both parents.
1	This level indicates a child who has had stable relationships but there is some concern about instability in the near future (one year) due to transitions, illness, or age. A stable relationship with only one parent may be rated here.
2	This level indicates a child has had at least one stable relationship over his/her lifetime but has experienced other instability through factors such as divorce, moving, removal from home, and death.
3	This level indicates a child who does not have any stability in relationships with any caregiver. Independent living or adoption must be considered.

CHILD STRENGTHS DOMAIN

	FAMILY STRENGTHS ***This item refers to the presence of a family identity, as well as love and communication among family members. Even families who are struggling often have a firm foundation that consists of a positive sense of family and strong underlying love and commitment to each other. As with Family Functioning, the definition of family comes from the child's perspective (i.e., who the child describes as his/her family). If you do not know this information, then we recommend a definition of family that includes biological/adoptive relatives and their significant others with whom the child is still in contact.***
0	Significant family strengths. This level indicates a family with much love and respect for one another. Family members are central in each other's lives. Child is full included in family activities.
1	Moderate level of family strengths. This level indicates a loving family with generally good communication and ability to enjoy each other's company. There may be some problems between family members.
2	Mild level of family strengths. Family is able to communicate and participate in each other's lives; however, family members may not be able to provide significant emotional or concrete support for each other.
3	This level indicates a child with no known family strengths. Child is not included in normal family activities.

	EXTENDED FAMILY RELATIONSHIPS ***This item rates the close relationships that the child has with extended family members.***
0	Infant/child has well established relationships with extended family that serve to support his/her growth and development. Family members are a significant support to parents and involved most of the time with infant/child.
1	Child has extended family relationships that are supportive most of the time. Extended family participates in the life of the child and his/her family much of the time.
2	Infant/child has infrequent contact with extended family members. The support the infant/child receives is not harmful but inconsistent.
3	Infant/child has no contact with extended family members or the contact with extended family is detrimental to the infant/child.

	INTERPERSONAL ***This item identifies a child's social and relationships skills. This strength indicates long standing relationship making and maintaining skills.***
0	Significant interpersonal strengths. Child has a prosocial or "easy" temperament and, if old enough, is interested and effective at initiating relationships with other children or adults. If still an infant, child exhibits anticipatory behavior when fed or held.
1	Moderate level of interpersonal strengths. Child has formed a positive interpersonal relationship with at least one non-caregiver. Child responds positively to social initiations by adults, but may not initiate such interactions by him-or herself.
2	Mild level of interpersonal strengths. Child may be shy or uninterested in forming relationships with others, or –if still an infant-child may have a temperament that makes attachment to others a challenge.
3	This level indicates a child with no known interpersonal strengths. Child does not exhibit any age-appropriate social gestures (e.g. Social smile, cooperative play, responsiveness to social initiations by non-caregivers). An infant that consistently exhibits gaze aversion would be rated here.

	ADAPTABILITY ***This item rates how the child reacts to new situations or experiences, as well as how s/he responds to changes in routines.***
0	Child has a strong ability to adjust to changes and transitions.
1	Child has the ability to adjust to changes and transitions, when challenged the infant/child is successful with caregiver support.
2	Child has difficulties much of the time adjusting to changes and transitions even with caregiver support.
3	Child has difficulties most of the time coping with changes and transitions. Adults are minimally able to impact child's difficulties in this area.

	PERSISTENCE ***This item rates the child's ability to keep trying a new task/skill, even when it is difficult for him/her.***
0	Infant/child has a strong ability to continue an activity when challenged or meeting obstacles.
1	Infant/child has some ability to continue an activity that is challenging. Adults can assist a child to continue attempting the task or activity.
2	Child has limited ability to continue an activity that is challenging and adults are only sometimes able to assist the infant/child in this area.
3	Child has difficulties most of the time coping with challenging tasks. Support from adults minimally impacts the child's ability to demonstrate persistence.

	CURIOSITY ***This rating describes the child's self-initiated efforts to discover his/her world. This item rates whether the child is interested in his/her surroundings and in learning and experiencing new things.***
0	This level indicates a child with exceptional curiosity. Infant displays mouthing and banging of objects within grasp; older children crawl or walk to objects of interest.
1	This level indicates a child with good curiosity. An ambulatory child who does not walk to interesting objects, but who will actively explore them when presented to him/her, would be rated here.
2	This level indicates a child with limited curiosity. Child may be hesitant to seek out new information or environments, or reluctant to explore even presented objects.
3	This level indicates a child with very limited or no observable curiosity.

CULTURAL FACTORS DOMAIN

	LANGUAGE ***This item looks at whether the child and family need help in communication with you or others in their world. It includes both spoken and sign language.***
0	Child and family speak English well.
1	Child and family speak some English but potential communication problems exist due to limits on vocabulary or understanding of the nuances of the language.
2	Child and/or significant family members do not speak English. Translator or native language speaker is needed for successful intervention but qualified individual can be identified within natural supports.
3	Child and/or significant family members do not speak English. Translator or native language speaker is needed for successful intervention and no such individual is available from among natural supports.

	CULTURAL IDENTITY ***This item refers to whether the child is experiencing any difficulties or barriers to their connection to their cultural identity. Cultural Identity may be defined by a number of factors including race, religion, ethnicity, geography or lifestyle.***
0	Child has clear and consistent cultural identity and is connected to others who share his/her cultural identity.
1	Child is experiencing some confusion or concern regarding cultural identity.
2	Child has significant struggles with his/her own cultural identity. Child may have cultural identity but is not connected with others who share this culture.
3	Child has no cultural identity or is experiencing significant problems due to conflict regarding his/her cultural identity.

	TRADITIONS AND RITUALS This ***item looks to identify whether barriers exist for a youth to engage in rituals relevant to his/her culture. Cultural rituals are activities and traditions that are culturally (or family) specific (e.g. the celebration of holidays such as kwanza, cinco de mayo, etc. Rituals also may include daily activities that are culturally specific (e.g. praying toward Mecca at specific times, eating a specific diet, access to media).***
0	Child and family are consistently able to practice rituals consistent with their cultural identity.
1	Child and family are generally able to practice rituals consistent with their cultural identity; however, they sometimes experience some obstacles to the performance of these rituals.
2	Child and family experience significant barriers and are sometimes prevented from practicing rituals consistent with their cultural identity.
3	Child and family are unable to practice rituals consistent with their cultural identity.

	CULTURAL STRESS This ***item identifies circumstances in which the youth's cultural identity is met with hostility or other problems within his/her environment due to differences in the attitudes, behaviors, or beliefs of others. Racism is a form of cultural stress as are all forms of discrimination.***
0	No evidence of stress between caregiver's cultural identify and current living situation.
1	Some mild or occasional stress resulting from friction between the caregiver's cultural identify and his/her current living situation.
2	Caregiver is experiencing cultural stress that is causing problems of functioning in at least one life domain. Caregiver needs to learn how to manage culture stress.
3	Caregiver is experiencing a high level of cultural stress that is making functioning in any life domain difficult under the present circumstances. Caregiver needs immediate plan to reduce culture stress.

	CULTURAL DIFFERENCES ***This item identifies cultural differences regarding child development and child rearing practices between the family and majority cultural values.***
0	The family does not have cultural differences related to child rearing practices, child development and early intervention that are considered by the majority culture as problematic for the child.
1	The family has some cultural differences related to child rearing practices, child development and early intervention that are not generally accepted but not considered to put the child at risk.
2	The family has cultural differences related to child rearing practices and development that are considered by the majority culture as problematic for the child.
3	The family has cultural differences related to child rearing practices and child development that is considered abusive or neglectful and may result in intervention.

CAREGIVER NEEDS AND RESOURCES DOMAIN

	SUPERVISION ***This item refers to the parent/caregiver's ability to provide monitoring and discipline to the rated child. Discipline is defined in the broadest sense as all of the things that parents/caregivers can do to promote positive behavior with their children.***
0	Caregiver has good monitoring and discipline skills.
1	Caregiver provides generally adequate supervision. May need occasional help or technical assistance.
2	Caregiver reports difficulties monitoring and/or disciplining child. Caregiver needs assistance to improve supervision skills.
3	Caregiver is unable to monitor or discipline the child. Caregiver requires immediate and continuing assistance. Child is at risk of harm due to absence of supervision.

	INVOLVEMENT ***This rating should be based on the level of involvement and follow-through the caregiver(s) has in the planning and provision of treatment, health, preschool/day care, child welfare, and related services.***
0	Caregiver is able to act as an effective advocate for child.
1	Caregiver has history of seeking help for their children. Caregiver is open to receiving support, education, and information.
2	Caregiver does not wish to participate in services and/or interventions intended to assist their child.
3	Caregiver wishes for child to be removed from their care.

	KNOWLEDGE ***This rating should be based on caregiver's knowledge of the specific strengths of the child and any needs experienced by the child and their ability to understand the rationale for the treatment or management of these problems.***
0	Caregiver is knowledgeable about the child's needs and strengths.
1	Caregiver is generally knowledgeable about the child but may require additional information to improve their capacity of parent.
2	Caregiver has clear need for information to improve how knowledgeable they are about the child. Current lack of information is interfering with their ability to parent.
3	Caregiver has knowledge problems that place the child at risk of significant negative outcomes.

	EMPATHY FOR CHILD ***This item refers to the parent/caregiver's ability to understand and respond to the joys, sorrows, anxieties and other feelings of children with helpful, supportive emotional responses.***
0	Caregiver is strong in his/her capacity to understand how the child is feeling and consistently demonstrates this in interactions with the child.
1	Caregiver has the ability to understand how the child is feeling in most situations and is able to demonstrate support for the child in this area most of the time.
2	Caregiver is only able to be empathetic toward the child in some situations and at times the lack of empathy interferes with the child's growth and development.
3	Caregiver shows no empathy for the child in most situations especially when the child is distressed. Caregiver's lack of empathy is impeding the child's development.

	ORGANIZATION ***This rating should be based on the ability of the parent/caregiver to participate in or direct the organization of the household, services, and related activities.***
0	Caregiver is well organized and efficient.
1	Caregiver has minimal difficulties with organizing and maintaining household to support needed services. For example, may be forgetful about appointments or occasionally fails to return case manager calls.
2	Caregiver has moderate difficulty organizing and maintaining household to support needed services.
3	Caregiver is unable to organize household to support needed services.

	SOCIAL RESOURCES ***This item refers to the financial and social assets (e.g. extended family) and resources that the caregiver(s) can bring to bear in addressing the multiple needs of the child and family.***
0	Caregiver has significant family and friend social network that actively helps with raising the child (e.g., child rearing).
1	Caregiver has some family or friend social network that actively helps with raising the child (e.g. child rearing).
2	Caregiver has some family or friend social network that may be able to help with raising the child (e.g., child rearing).
3	Caregiver no family or social network that may be able to help with raising the child (e.g. child rearing).

	RESIDENTIAL STABILITY ***This item rates the parent/caregiver's current and likely future housing circumstances.***
0	Caregiver has stable housing for the foreseeable future.
1	Caregiver has relatively stable housing but either has moved in the past three months or there are indications of housing problems that might force them to move in the next three months.
2	Caregiver has moved multiple times in the past year. Housing is unstable.
3	Caregiver has experienced periods of homelessness in the past six months.

	PHYSICAL ***Physical health includes medical and physical challenges faced by the parent/caregiver(s).***
0	Caregiver is generally healthy.
1	Caregiver is in recovery from medical/physical problems.
2	Caregiver has medical/physical problems that interfere with their capacity to parent.
3	Caregiver has medical/physical problems that make it impossible for them to parent at this time.

	MENTAL HEALTH ***This item refers to the parent/caregiver's mental health status. Serious mental illness would be rated as a '2' or '3' unless the individual is in recovery or successfully managing illness.***
0	Caregiver has no mental health needs.
1	Caregiver is in recovery from mental health difficulties.
2	Caregiver has some mental health difficulties that interfere with their capacity to parent.
3	Caregiver has mental health use difficulties that make it impossible for them to parent at this time.

	SAFETY ***This rating refers to the safety of the assessed child. It does not refer to the safety of other family or household members based on any danger presented by the assessed child.***
0	Household is safe and secure. Child is at no risk from others. This level indicates that the present placement environment is as safe or safer for the child (in his or her present condition) as could be reasonably expected.
1	Household is safe but concerns exist about the safety of the child due to history or others in the neighborhood who might be abusive. This level indicates that the present placement environment presents some mild risk of neglect, exposure to undesirable environments (e.g. drug use or gangs in the neighborhood, etc.) but that no immediate risk is present.
2	Child is in some danger from one or more individuals with access to the household. This level indicates that the present placement environment presents a moderate level of risk to the child, including such things as the risk of neglect or abuse or exposure to individual who could harm the child.
3	Child is in immediate danger from one or more individuals with unsupervised access. This level indicates that the present placement environment presents a significant risk to the well being of the child. Risk or neglect or abuse is imminent and immediate. An individual in the environment offers the potential of significantly harming the child.

***All referents are legally required to report suspected child abuse or neglect to the hotline**

	DEVELOPMENTAL ***This item describes the parent/caregiver's developmental status in terms of low IQ, intellectual disability or other developmental disabilities and the impact of these conditions on his/her ability to care for child.***
0	Caregiver has no developmental needs.
1	Caregiver has developmental challenges but they do not currently interfere with parenting.
2	Caregiver has developmental challenges that interfere with their capacity to parent.
3	Caregiver has severe developmental challenges that make it impossible for them to parent at this time.

	ACCESSIBILITY TO CHILD CARE SERVICES ***This item refers to the caregiver's access to appropriate child care for young children.***
0	Caregiver has access to sufficient child care services.
1	Caregiver has limited access to child care services. Needs are met minimally by existing, available services.
2	Caregiver has limited access or access to limited child care services. Current services do not meet the caregiver's needs.
3	Caregiver has no access to child care services.

	FAMILY STRESS ***This item rates the impact of the managing the child's needs on the caregiver(s).***
0	Caregiver able to manage the stress of child/children's needs.
1	Caregiver has some problems managing the stress of child/children's needs.
2	Caregiver has notable problems managing the stress of child/children's needs. This stress interferes with their capacity to give care.
3	Caregiver is unable to manage the stress associated with child/children's needs. This stress prevents caregiver from parenting.

	MARITAL/PARTNER VIOLENCE IN THE HOME ***This rating describes the degree of difficulty or conflict in the parent/caregiver's relationship and the impact on parenting and childcare.***
0	Parent/caregiver(s) appear to be functioning adequately. There is no evidence of notable conflict in the parenting relationship. Disagreements are handled in an atmosphere of mutual respect and equal power.
1	Mild to moderate level of family problems including marital difficulties and partner arguments. Parent/caregivers are generally able to keep arguments to a minimum when child is present. Occasional difficulties in conflict resolution or use of power and control by one partner over another.
2	Significant level of caregiver difficulties including frequent arguments that often escalate to verbal aggression, the use of verbal aggression by one partner to control the other or significant destruction of property. Child often witnesses these arguments between caregivers, the use of verbal aggression by one partner to control the other or significant destruction of property.
3	Profound level of caregiver or marital violence that often escalates to the use of physical aggression by one partner to control the other. These episodes may exacerbate child's difficulties or put the child at greater risk.

	ABUSE and/or NEGLECT ***This item refers to physical, emotional, or sexual abuse occurring, or at risk of occurring in the child's living situation, AND/OR the failure to provide adequate supervision and expectations and access to the basic necessities of life, including food, shelter, and clothing****.*
0	No evidence of emotional, physical, sexual abuse or neglect.
1	Mild level of emotional abuse or occasional spanking without physical harm, or intention to commit harm. No sexual abuse. OR Mild level of neglect of caretaker responsibilities, such as failure to provide adequate expectations or supervision to child.
2	Moderate level of emotional abuse and/or frequent spanking or other forms of physical punishment. OR Moderate level of neglect, including some supervision and occasional unintentional failure to provide adequate food, shelter, or clothing, with rapid corrective action.
3	Severe level of emotional or physical abuse with intent to do harm and/or actual physical harm, or any form of sexual abuse. This would include regular beatings with physical harm and frequent and ongoing emotional assaults. OR Severe level of neglect, including prolonged absences by adults, without minimal supervision, and failure to provide basic necessities of life on a regular basis.

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CHILD BEHAVIORAL/EMOTIONAL NEED DOMAIN

	ATTACHMENT DIFFICULTIES This ***item rates the relationship between the parent/primary caregiver and the child.***
0	No evidence of problems with attachment.
1	Mild problems with attachment are present. Infants appear uncomfortable with caregivers, may resist touch, or appear anxious and clingy some of the time. Caregivers feel disconnected from infant. Older children may be overly reactive to separation or seem preoccupied with parent. Boundaries may seem inappropriate with others.
2	Moderate problems with attachment are present. Infants may fail to demonstrate stranger anxiety or have extreme reactions to separation resulting in interference with development. Older children may have ongoing problems with separation, may consistently avoid caregivers and have inappropriate boundaries with others putting them at risk.
3	Severe problems with attachment are present. Infant is unable to use caregivers to meet needs for safety and security. Older children present with either an indiscriminate attachment patterns or a withdrawn, inhibited attachment patterns. A child that meets the criteria for Reactive Attachment Disorder would be rated here.

	REGULATORY: BODY CONTROL/EMOTIONAL CONTROL ***This item refers to the child's ability to control bodily functions such as eating, sleeping and elimination as well as activity level/intensity and sensitivity to external stimulation. The child's ability to control and modulate intense emotions is also rated here.***
0	No evidence of regulatory problems.
1	Some problems with regulation are present. Infants may have unpredictable patterns and be difficult to console. Older children may require a great deal of structure and need more support than other children in coping with frustration and difficult emotions.
2	Moderate problems with regulation are present. Infants may demonstrate significant difficulties with transitions, and irritability such that consistent adult intervention is necessary and disruptive to the family. Older children may demonstrate severe reactions to sensory stimuli and emotions that interfere with their functioning and ability to progress developmentally. Older children may demonstrate such unpredictable patterns in their eating and sleeping routines that the family is disrupted and distressed.
3	Profound problems with regulation are present that place the child's safety, well being and/or development at risk.

	FAILURE TO THRIVE ***This item rates the presence of problems with weight gain or growth. Symptoms of failure to thrive focus on normal physical development such as growth and weight gain.***
0	No evidence of failure to thrive.
1	The infant/child may have experienced past problems with growth and ability to gain weight and is currently not experiencing problems. The infant/child may presently be experiencing slow development in this area.
2	The infant or child is experiencing problems in their ability to maintain weight or growth. The infant or child may be below the 5th percentile for age and sex, may weigh less than 80% of their ideal weight for age, have depressed weight for height, have a rate of weight gain that causes a decrease in two or more major percentile lines over time, (75th to 25th).
3	The infant/child has one or more of all of the above and is currently at serious medical risk.

	DEPRESSION ***This item refers to any symptoms of depression which may include sadness, irritable mood most of the day nearly every day, changes in eating and sleeping, and diminished interest in playing or activities that were once of interest. A rating of '2' could be a two year old who is often irritable, does not enjoy playing with toys as s/he used to, is clingy to his/her caregiver, and is having sleep issues.***
0	No evidence of problems with depression.
1	There are some indicators that the child may be depressed or has experienced situations that may lead to depression. Infants may appear to be withdrawn and slow to engage at times during the day. Older children are irritable or do not demonstrate a range of affect.
2	Moderate problems with depression are present. Infants demonstrate a change from previous behavior and appear to have a flat affect with little responsiveness to interaction most of the time. Older children may have negative verbalizations, dark themes in play and demonstrate little enjoyment in play and interactions. The child meets criteria for a DSM IV diagnosis.
3	Clear evidence of disabling level of depression that makes it virtually impossible for the child to function in any life domain. This rating is given to a child with a severe level of depression.

	ANXIETY ***This item describes the child's level of fearfulness, worrying or other characteristics of anxiety.***
0	No evidence
1	History or suspicion of anxiety problems or mild to moderate anxiety associated with a recent negative life event. An infant may appear anxious in certain situations but has the ability to be soothed. Older children may appear in need of extra support to cope with some situations but are able to be calmed.
2	Clear evidence of anxiety associated with either anxious mood or significant fearfulness. Anxiety has interfered significantly in child's ability to function in at least one life domain. Infants may be irritable, over reactive to stimuli, have uncontrollable crying and significant separation anxiety. Older children may have all of the above with persistent reluctance or refusal to cope with some situations.
3	Clear evidence of debilitating level of anxiety that makes it virtually impossible for the child to function in any life domain.

	ATYPICAL BEHAVIORS ***This item rates whether the child repeats certain actions over and over again, or demonstrates behaviors that are unusual or difficult to understand. Behaviors may include mouthing after 1 year, head banging, smelling objects, spinning, twirling, hand flapping, finger-flicking, rocking, toe walking, staring at lights, or repetitive and bizarre verbalizations This is important in early childhood to assess due to the possible indication that this may be related to an autism spectrum disorder. Early intervention to assess the etiology of these symptoms is critical.***
0	No evidence of atypical behaviors in the infant/child
1	History or reports of atypical behaviors from others that have not been observed by caregivers.
2	Clear evidence of atypical behaviors reported by caregivers that are observed on an ongoing basis.
3	Clear evidence of atypical behaviors that are consistently present and interfere with the infants/child's functioning on a regular basis.

	IMPULSIVITY/HYPERACTIVITY ***This item refers to the child's level of difficulty controlling activity level or actior This item refers to both a child's ability to control impulses as well as his/her activity level.*** **The child should be 3 years of age or older to rate this item.**
0	No evidence
1	Some problems with impulsive, distractible or hyperactive behavior that places the child at risk of future functioning difficulties.
2	Clear evidence of problems with impulsive, distractible, or hyperactive behavior that interferes with the child's ability to function in at least one life domain. The child may run and climb excessively even with adult redirection. The child may not be able to sit still even to eat and is often into things. The child may blurt out answers to questions without thinking, have difficulty waiting turn and intrude on others space.
3	Clear evidence of a dangerous level of impulsive and hyperactive behavior that can place the child at risk of physical harm.

	OPPOSITIONAL (Compliance with authority) ***This item is intended to capture how the child relates to authority. Oppositional behavior refers to reactions towards adults, not peers.*** **The child should be 3 years of age or older to rate this item.**
0	No evidence
1	History or recent onset (past 6 weeks) of defiance towards authority figures
2	Clear evidence of oppositional and/or defiant behavior towards authority figures, which is currently interfering with the child's functioning in at least one life domain. Behavior is persistent and caregiver's attempts to change behavior have failed.
3	Clear evidence of a dangerous level of oppositional behavior involving the threat of physical harm to others or problems in more than one life domain that is resulting in interference with child's social and emotional development.

	ADJUSTMENT TO TRAUMA. ***This item covers the child's reaction to any of a variety of traumatic experiences—such as emotional, physical, or sexual abuse, disasters, neglect, separation from family members, witnessing violence, or the victimization or murder of family members or close friends.*** ***This item should be rated 1 -3 for individuals who are exhibiting any symptoms related to a traumatic or adverse experience in their past. The item allows you to rate the overall severity of the broad range of symptoms the child may be experiencing. The remaining items in the CANS will allow you to rate the specific types of symptoms. (Adjustment to Trauma language Adapted from Kisiel, et al., 2011)*** ***<u>If abuse or neglect of the child/youth has been substantiated by child welfare, the rating would be a 1, 2, or 3</u>.***
0	Child has not experienced any significant trauma or has adjusted well to traumatic/adverse child experiences.
1	History or suspicion of problems associated with traumatic life event/s. Child has some **mild** problems with adjustment due to trauma that might ease with the passage of time. This may include one or mental health difficulty (such as depression, sleep problems) that may be associated with their trauma history. Child may also be in the process of recovering from a more extreme reaction to a traumatic experience.
2	Clear evidence of **moderate** adjustment problems associated with traumatic life event/s. Adjustment is interfering with child's functioning in at least one life domain. Symptoms can vary widely and may include sleeping or eating disturbances, regressive behavior, behavior problems or problems with attachment. Child may have features of one or more diagnoses and may meet full criteria for a specific DSM diagnosis including but not limited to diagnoses of Post-Traumatic Stress Disorder (PTSD) or Adjustment Disorder.
3	Clear evidence of **severe** adjustment problems associated with traumatic life event/s, which may include flashbacks, nightmares, significant anxiety, and intrusive thoughts, re-experiencing trauma (consistent with PTSD). OR Child likely meets criteria for more than one diagnosis or may have several symptoms consistent with complex trauma (e.g. problems with attachment, affect and behavioral regulation, cognition/learning, etc.). Child has severe symptoms as a result of traumatic or adverse childhood experiences that **require intensive** or **immediate attention**.

CHILD RISK FACTOR DOMAIN

	BIRTH WEIGHT ***This dimension describes the child's weight as compared to normal development.***
0	Child is within normal range for weight and has been since birth. A child 5.5 pounds or over would be rated here.
1	Child was born underweight but is now within normal range or child is slightly beneath normal range. A child with a birth weight of between 3.3 pounds and 5.5 pounds would be rated here.
2	Child is considerably under weight to the point of presenting a developmental risk to the child. A child with a birth weight of 2.2 pounds to 3.3 pounds would be rated here.
3	Child is extremely under weight to the point of the child's life being threatened. A child with a birth weight of less than 2.2 pounds would be rated here.

	PICA ***Pica refers to the child eating dangerous or unusual materials. This dimension includes the symptoms of Pica as specified in DSM.*** **Child must be older than 18 months to rate this item.**
0	No evidence that the child eats unusual or dangerous materials.
1	Child has a history of eating unusual or dangerous materials but has not done so in the last 30 days.
2	Child has eaten unusual or dangerous materials consistent with a diagnosis of Pica in the last 30 days.
3	Child has become physically ill during the past 30 days by eating dangerous materials.

	PRENATAL CARE ***This dimension refers to the health care and birth circumstances experienced by the child in utero.***
0	Child's biological mother received adequate prenatal care that began in the first trimester. Child's mother did not experience any pregnancy related illnesses.
1	Child's biological mother had some short-comings in prenatal care, or had a mild form of a pregnancy related illness.
2	Child's biological mother received poor prenatal care, initiated only in the last trimester or had a moderate form of a pregnancy related illness.
3	Child's biological mother had no prenatal care or had a severe pregnancy related illness.

	LABOR AND DELIVERY ***This dimension refers to conditions associated with, and consequences arising from complications in labor and delivery of the child.***
0	Child and biological mother had normal labor and delivery.
1	Child or mother had some mild problems during delivery, but child does not appear affected by problems.
2	Child or mother had problems during delivery that resulted in temporary functional difficulties for the child or mother.
3	Child had severe problems during delivery that have resulted in long term implications for development.

	SUBSTANCE EXPOSURE ***This dimension refers to conditions associated with, and consequences arising from complications in labor and delivery of the child.***
0	Child had no in utero exposure to alcohol or drugs, and there is no current exposure in the home.
1	Child had either mild in utero exposure or there is current alcohol and/or drug use in the home.
2	Child was exposed to significant alcohol or drugs in utero. Any ingestion of illegal drugs during pregnancy or significant use of alcohol or tobacco would be rated here.
3	Child was exposed to alcohol or drugs in utero and continues to be exposed in the home.

	PARENT OR SIBLING PROBLEMS ***This dimension describes how this child's parents and older siblings have done/are doing in their respective developments.***
0	The child's parents have no developmental disabilities. The child has no siblings, or existing siblings are not experiencing any developmental or behavioral problems.
1	The child's parents have no developmental disabilities. The child has siblings who are experiencing some mild developmental or behavioral problems. It may be that the child has at least one healthy sibling.
2	The child's parents have no developmental disabilities. The child has a sibling who is experiencing a significant developmental or behavioral problem.
3	One or both of the child's parents have been diagnosed with a developmental disability, or the child has multiple siblings who are experiencing significant developmental or behavioral problems.

	PARENTAL AVAILABILITY ***This dimension addresses the primary caretaker's emotional and physical availability to the child in the weeks immediately following the birth. Rate maternal availability up until 12 weeks postpartum.***
0	The child's parent/primary caretaker was emotionally and physically available to the child in the weeks following the birth.
1	The primary caretaker experienced some minor or transient stressors which made the parent slightly less available to the child.
2	The primary caregiver experienced a moderate level of stress sufficient to make him/her significantly less emotionally and physically available to the child in the weeks following the birth.
3	The primary caregiver was unavailable to the child to such an extent that the child's emotional or physical well being was severely compromised.

CHILD RISK BEHAVIOR DOMAIN

	SELF HARM
0	No evidence
1	Mild level of self harm behavior or history of self harm.
2	Moderate level of self harm behavior such as head banging that cannot be impacted by caregiver and interferes with child's functioning.
3	Severe level of self harm behavior that puts the child's safety and well being at risk.

	AGGRESSIVE BEHAVIOR ***This item rates whether there have been times when the child hurt or threatened to hurt another child or adult.***
0	No evidence of aggressive behavior towards people or animals.
1	There is either a history of aggressive behavior towards people or animals or mild concerns in this area that have not yet interfered with functioning.
2	There is clear evidence of aggressive behavior towards animals or others. Behavior is persistent, and caregiver's attempts to change behavior have not been successful. Help is needed.
3	The child has significant challenges in this area that is characterized as a dangerous level of aggressive behavior that involves harm to animals or others. Caregivers have difficulty managing this behavior.

	INTENTIONAL MISBEHAVIOR (Social Behavior) ***This item refers to obnoxious behaviors that force adults to sanction the child. These behaviors occur in such a way that the child is intentionally seeking negative attention, acting out, or the behavior could be seen as a cry for help. It is not necessary that the child have an awareness of the purpose of his/her misbehavior as it is not always conscious or planned. This item should not be rated for children who engage in such behavior solely due to developmental delays or lack of social skill.*** **The child should be 3 years of age or older to rate this item.**
0	No evidence of problematic social behavior. Child does not engage in behavior that forces adults to sanction him/her.
1	**Mild** level of intentional misbehavior. This might include occasional inappropriate social behavior that forces adults to sanction the child. Infrequent inappropriate comments to strangers or unusual behavior in social settings might be included in this level.
2	**Moderate** level of problematic intentional misbehavior. Such behavior is causing problems in the child's life. Child may be intentionally getting in trouble in preschool or at home.
3	**Severe** level of problematic intentional misbehavior. This level would be indicated by frequent serious misbehavior that forces adults to seriously and/or repeatedly sanction the child. Behaviors are sufficiently severe that they place the child at risk of significant sanctions (e.g. expulsion from preschool, removal from the home, or community).

INDIVIDUALIZED ASSESSMENT MODULES

Complete any specific module only if indicated on the initial page(s)

SCHOOL MODULE

	PRESCHOOL/DAYCARE QUALITY ***This item rates the overall quality of the preschool or daycare as well as the ability of the program to meet the needs of the child within a larger care giving context.***
0	Infant/child's preschool/daycare meets the needs of the infant/child.
1	Infant/child's preschool/daycare is marginal in its ability to meet the needs of the infant/child. Caregivers may be inconsistent or curriculum may be weak in areas.
2	Infant/child's preschool/daycare does not meet the needs of the infant/child in most areas. Care giving may not support the child's growth or promote further learning.
3	The infant/child's preschool/daycare is contributing to problems for the infant/child in one or more areas.

	PRESCHOOL/DAYCARE BEHAVIOR ***This item rates the child's behavior in day care or preschool. This is rated independently from attendance. Sometimes children are often absent but when they are in school they behave appropriately. If the child's behavior is disruptive and multiple interventions have been tried, rate this item '2'. If the day care/preschool placement is in jeopardy due to behavior, this would be rated a "3."***
0	Child is behaving well in preschool/daycare.
1	Child is behaving adequately in preschool/daycare although some mild behavior problems may exist. Child may have a history of behavioral problems.
2	Child is having moderate behavioral problems at school. He/she is disruptive and many types of interventions have been implemented.
3	Child is having severe problems with behavior in preschool/daycare. He/she is frequently or severely disruptive. The threat of expulsion is present.

	PRESCHOOL/DAY CARE ACHIEVEMENT ***This item rates the child's level of developmentally appropriate achievement.***
0	Child is doing well acquiring new skills.
1	Child is doing adequately acquiring new skills with some challenges. Child may be able to compensate with extra adult support.
2	Child is having moderate problems with acquiring new skills. Child may not be able to retain concepts or meet expectations even with adult support in some areas.
3	Child is having severe achievement problems. Child may be completely unable to understand or participate in skill development in most or all areas.

	PRESCHOOL/DAYCARE ATTENDANCE ***This item assesses the degree to which the child attends preschool or day care.***
0	Child attends preschool/daycare regularly.
1	Child has some problems attending preschool/daycare but generally is present. May miss up to one day per week on average OR may have had moderate to severe problem in the past six months but has been attending regularly in the past month.
2	Child is having problems with school attendance. He/she is missing at least two days each week on average.
3	Child is absent most of the time and this causes a significant challenge in achievement, socialization and following routine.

DEVELOPMENTAL DISABILITY (DD) MODULE

This module describes the child's current developmental functioning (last 30 days). Please rate based on relevant information from all sources.

	COGNITIVE ***This item identifies the individual's intellectual or cognitive capacity.***
0	There is no evidence of cognitive development problems.
1	Infant/child has some indicators that cognitive skills are not appropriate for age or are at the upper end of age expectations. Infants may not consistently demonstrate familiarity with routines and anticipatory behavior. Infants may seem unaware of surroundings at times. Older children may have challenges in remembering routines, and completing tasks such as sorting, or recognizing colors some of the time.
2	Infant/child has clear indicators that cognitive development is not at expected level and interferes with functioning much of the time. Infants may not have the ability to indicate wants/needs. Infants may not demonstrate anticipatory behavior all or most of the time. Older children may be unable to demonstrate understanding of simple routines or the ability to complete simple tasks.
3	Infant/child has significant delays in cognitive functioning that are seriously interfering with their functioning. Infant/child is completely reliant on caregiver to function.

	SELF-CARE DAILY LIVING SKILLS ***This item rates the individual's ability to participate in self-care activities, including eating, bathing, dressing and toileting.***
0	Child's self-care and daily living skills appear developmentally appropriate. There is no reason to believe that the child has any problems performing daily living skills.
1	Child requires some assistance on self-care tasks or daily living skills at a greater level than would be expected for age. Development in this area may be slow. Infants may require greater than expected level of assistance in eating and may demonstrate a lack of progression in skills.
2	Infant/ child requires consistent assistance (physical prompting) on developmentally appropriate self-care tasks and/or does not appear to be developing the needed skills in this area.
3	Child is not able to function independently at all in this area.

FAMILY/CARETAKER MODULE

	EMPLOYMENT/EDUCATIONAL FUNCTIONING ***This item rates the performance of the caregiver in school or work settings. This performance can include issues of behavior, attendance or achievement/productivity***.
0	Caregiver is gainfully employed and/or in school.
1	A mild degree of problems with school or work functioning. Caregiver may have some problems in work environment. Caregiver needs to be monitored and assessed further.
2	A moderate degree of school or work problems and/or difficulties with learning. Caregiver may have history of frequent job loss or may be recently unemployed. Caregiver needs an intervention to address employment and/or learning difficulties.
3	A severe degree of school or work problems. Caregiver is chronically unemployed and not attending any education program. Caregiver needs immediate intervention.

	LEGAL ***This item rates the family's involvement in the criminal justice system.***
0	Caregiver has no known legal difficulties.
1	Caregiver has a history of legal problems but currently is not involved with the legal system.
2	Caregiver has some legal problems and is currently involved in the legal system.
3	Caregiver has serious current or pending legal difficulties that place him/her at risk for incarceration. Caregiver needs an immediate comprehensive and community-based intervention.

	MOTIVATION FOR CARE ***This rating captures the desire of the caregiver to support their youth in care. The person need not have an understanding of their illness; however they participate in recommended or prescribed care (e.g., taking prescribed medications and cooperating with care providers).***
0	The caregiver is engaged in his/her youth's care and supports his/her youth in participating in care.
1	The caregiver is willing for his/her youth to participate in care; however the caregiver may need prompts at times. Caregiver needs to be monitored and assessed further.
2	The caregiver is often unwilling to support his/her youth's care and is often uncooperative with service providers. Caregiver/youth needs to be engaged in care.
3	The caregiver refuses to allow his/her youth to participate in care including taking prescribed medications or cooperating with recommended care. Service coordinator needs to meet with referral source and team to revisit goals.

	FINANCIAL RESOURCES
0	Caregiver has sufficient financial resources to raise the youth (e.g., youth rearing).
1	Caregiver has some financial resources that actively help with raising the youth (e.g. youth rearing).
2	Caregiver has limited financial resources that may be able to help with raising the youth (e.g., youth rearing).
3	Caregiver has no financial resources to help with raising the youth (e.g. youth rearing). Caregiver needs financial resources

	TRANSPORTATION ***This rating reflects the caregiver's ability to provide appropriate transportation for his/her youth.***
0	Youth and his/her caregiver have no transportation needs. Caregiver is able to get his/her youth to appointments, school, activities, etc. consistently.
1	Youth and his/her caregiver have occasional transportation needs (e.g. appointments). Caregiver has difficulty getting his/her youth to appointments, school, activities, etc. no more than weekly.
2	Youth and his/her caregiver have frequent transportation needs. Caregiver has difficulty getting his/her youth to appointments, school, activities, etc. regularly (e.g., once a week). Caregiver needs assistance transporting youth and access to transportation resources.
3	Youth and his/her caregiver have no access to appropriate transportation and is unable to get his/her youth to appointments, school, activities, etc. Caregiver needs immediate intervention and development of transportation resources.

TRAUMA MODULE

<u>Rating Guide</u> for Characteristics of Potentially Traumatic/Adverse Experiences Section

0 – No evidence of any trauma of this type
1 – A single incident of trauma occurred or suspicion exists of this type of trauma
2 – Multiple incidents or a moderate degree of trauma of this type
3 – Repeated and severe incidents of trauma of this type

Potentially Adverse Traumatic Experiences are rated over the <u>lifetime</u> of the child:

	SEXUAL ABUSE ***This rating describes the child's experience of sexual abuse.***
0	There is **no evidence** that child has experienced sexual abuse.
1	There is a **suspicion** that the child has experienced sexual abuse **with some degree of evidence** or the child has **experienced "mild" sexual abuse** including but not limited **to direct exposure to sexually explicit materials**. Evidence for suspicion of sexual abuse could include evidence of **sexually reactive behavior** as well as **exposure to a sexualized environment** or **Internet predation**. Children who have experiences secondary sexual abuse (e.g. **witnessing sexual abuse, having a sibling sexually abused**) would also be rated here.
2	Child has experienced **one or a couple of incidents** of sexual abuse that were not chronic or severe. This might include a child who has experienced molestation without penetration on a single occasion.
3	Child has experienced **severe** or **chronic** sexual abuse with **multiple episodes or lasting over an extended period of time**. This abuse may have involved **penetration, multiple perpetrators, and/or associated physical injury**.

	PHYSICAL ABUSE ***This rating describes the child's experience of physical abuse.***
0	There **is no evidence** that child has experienced physical abuse.
1	There is a **suspicion** that child has experienced physical abuse **but no confirming evidence**. **Spanking** without physical harm or threat of harm also qualifies.
2	Child has experienced **a moderate level of physical abuse** and/or **repeated forms of physical punishment** (e.g. hitting, punching).
3	Child has experienced **severe and repeated physical abuse** with intent to do harm and that causes sufficient physical harm to necessitate hospital treatment.

	NEGLECT ***This rating describes the degree of severity of neglect an individual has experienced. Neglect can refer to a lack of food, shelter or supervision (physical neglect) or lack of access to needed medical care (medical neglect), or failure to receive an academic instruction (educational neglect).***
0	There is **no evidence** that child has experienced neglect.
1	Child has experienced **minor occasional** neglect. Child may have been l**eft home alone for a short period of time** with no adult supervision or there may be **occasional failure to provide adequate supervision of child.**
2	Child has experienced a **moderate level** of neglect. Child may have been left **home alone overnight** or there may be **occasional failure to provide adequate food, shelter, or clothing with corrective action**
3	Child has experienced a **severe level of neglect** including multiple and/or prolonged absences by adults, with minimal supervision, and **failure to provide basic necessities of life on a regular basis.**

	EMOTIONAL ABUSE ***The rating describes the degree of severity of emotional abuse, including verbal and nonverbal forms. This item includes both "emotional abuse," which would include psychological maltreatment such as insults or humiliation towards a child and "emotional neglect" defined as the denial of emotional attention and /or support from caregivers.***
0	There is **no evidence** that child has experienced emotional abuse.
1	Child has experienced **mild** emotional abuse. For instance, child may experience some insults or is **occasionally referred to in a derogatory manner** by caregivers.
2	Child has experienced a **moderate degree of emotional** abuse. For instance, child may be **consistently denied emotional attention** from caregivers, **insulted or humiliated on an ongoing basis**, or **intentionally isolated** from others.
3	Child has experienced **significant or severe** emotional abuse over an extended period of time (at least one year). For instance, child is **completely ignored** by caregivers, or **threatened/terrorized** by others.

	MEDICAL TRAUMA ***This rating describes the severity of medical trauma. Not all medical procedures are experienced as traumatic. Medical trauma results when a medical experience is perceived by the child as mentally or emotionally overwhelming. Potential medical trauma include but are not limited to the following examples: the onset of a life threatening illness; sudden painful medical events; chronic medical conditions resulting from an injury or illness or another type of traumatic event.***
0	There is **no evidence** that child has experienced any medical trauma.
1	Child has had a medical experience that was **mildly overwhelming** for the child. Examples include events that were **acute in nature** and d**id not result in ongoing medical needs and associated distress** such as minor surgery, stitches or bone setting.
2	Child has had a medical experience that was perceived as **moderately** emotionally or mentally overwhelming. Such events **might include** acute injuries and **moderately invasive medical procedures** such as major surgery that require only short term hospitalization.
3	Child has had a medical experience that was perceived as **extremely** emotionally or mentally **overwhelming**. The event itself may have been life **threatening** and may have resulted in chronic health problems that alter the child's physical functioning.

	NATURAL or MANMADE DISASTER ***This rating describes the severity of exposure to natural disasters.***
0	There is **no evidence** that child has experienced any natural or manmade disaster.
1	Child has been **exposed to disasters second-hand** (i.e. on television, hearing others discuss disasters). This would include second –hand exposure to natural disasters such as a fire or earthquake or man-made disaster, including care accident, plane crashes, or bombing.
2	Child has been **directly exposed to a disaster or witnessed the impact of a disaster on a family or friend.** For instance, a child may observe a caregiver who has been injured in a car accident or fire or watch his neighbor's house burn down.
3	Child has been directly exposed to **multiple and severe natural or manmade disasters** and /or a disaster **that caused significant harm or death to a loved one or there is an ongoing impact or life disruption** due to the disaster (e.g. house burns down, caregiver loses job).

	WITNESS TO FAMILY VIOLENCE ***This rating describes the severity of exposure to family violence.***
0	There is **no evidence** that child has witnessed family violence.
1	Child has witnessed **one episode** of family violence.
2	Child has witnessed **repeated episodes** of family violence but no significant injuries (i.e. requiring emergency medical attention) have been witnessed.
3	Child has witnessed **repeated and severe episodes** of family violence or has had to intervene in episodes of family violence. **Significant injuries** have occurred and have been **witnessed** as a direct result of the violence.

	COMMUNITY VIOLENCE ***This rating describes the severity of exposure to community violence.***
0	There is no **evidence** that child has witnessed violence in the community.
1	Child has witnessed **occasional fighting or other forms of violence** in the community. Child has **not been directly impacted** by the community violence (i.e. violence not directed at self, family, or friends) and exposure has been limited.
2	Child has **witnessed multiple instances** of community violence and/**or the significant injury of others** in his/her community, or has **had friends/family members injured** as a result of violence or criminal activity in the community, or is the **direct victim** of violence/criminal activity that was **not life threatening.**
3	Child has witnessed or experienced **severe and repeated instances** of community violence **and/or the death of another person in his/her community** as a result of violence, or is the **direct victim** of violence/criminal activity in the community that was **life threatening**, **or has experienced chronic/ongoing impact as a result** of community violence (e.g. family member injured and no longer able to work).

	WITNESS/VICTIM TO CRIMINAL ACTIVITY ***This rating describes the severity of exposure to criminal activity. Criminal behavior includes any behavior for which an adult could go to prison including drug dealing, prostitution, assault, or battery.***
0	There is **no evidence** that child has been victimized or witness significant criminal activity.
1	There is **a strong suspicion or evidence** that Child is a witness of **at least one significant criminal activity.**
2	Child has witnessed **multiple criminal activities** and/or is a **direct victim** of criminal activity or **witnessed the victimization of a family or friend.**
3	Child has been **exposed to chronic and/or severe instances of criminal activity** and/or is a **direct victim** of criminal activity that was **life threatening or caused significant physical harm** or child witnessed the **death of a loved one**.

	WAR/TERRORISM AFFECTED ***This rating describes the degree of severity of exposure to war, political violence, torture or terrorism.***
0	No evidence that the child has been exposed to war, political violence, torture or terrorism.
1	There is suspicion that the child has experienced or been affected by war, terrorism or political violence.
2	Child has experienced or been affected by war, terrorism or political violence. Examples include: Family members directly related to the child may have been exposed to war, political violence, or torture resulting in displacement, injury or disability, or death; parents may have been physically or psychologically disabled from the war and are unable to adequately care for the child; child may have spent an extended amount of time in a refugee camp, or feared for his/her own life during war or terrorism due to bombings or shelling very near to him/her. Child who did not live in war or terrorism-affected region or refugee camp, but family was affected by war.
3	Child has been exposed to chronic and/or severe instances war or terrorism and/or is a direct victim of political violence or terrorism that was life threatening or caused significant physical harm or child witnessed the death of a loved one. Child may have been directly injured, tortured, or kidnapped in a terrorist attack.

If a child has been sexually abused, rate the following items:

	EMOTIONAL CLOSENESS TO PERPETRATOR
0	Perpetrator was a stranger at the time of the abuse.
1	Perpetrator was known to the child at the time of event but only as an acquaintance.
2	Perpetrator had a close relationship with the child at the time of the event but was not an immediate family member.
3	Perpetrator was an immediate family member (e.g. parent, sibling).

	FREQUENCY OF ABUSE
0	Abuse occurred only one time.
1	Abuse occurred two times.
2	Abuse occurred two to ten times.
3	Abuse occurred more than ten times.

	DURATION
0	Abuse occurred only one time.
1	Abuse occurred within a six month time period.
2	Abuse occurred within a six-month to one year time period.
3	Abuse occurred over a period of longer than one year.

	FORCE
0	No physical force or threat of force occurred during the abuse episode(s).
1	Sexual abuse was associated with threat of violence but no physical force.
2	Physical force was used during the sexual abuse.
3	Significant physical force/violence was used during the sexual abuse. Physical injuries occurred as a result of the force.

	REACTION TO DISCLOSURE
0	All significant family members are aware of the abuse and supportive of the child coming forward with the description of his/her abuse experience.
1	Most significant family members are aware of the abuse and supportive of the child for coming forward. One or two family members may be less supportive. Parent may be experiencing anxiety/depression/guilt regarding abuse.
2	Significant split among family members in terms of their support of the child for coming forward with the description of his/her experience.
3	Significant lack of support from close family members of the child for coming forward with the description of his/her abuse experience. Significant relationship (e.g. parent, care-giving grandparent) is threatened.

Rate Traumatic Stress Symptoms for all Children with Trauma Experience:

	EMOTIONAL and/or PHYSICAL DYSREGULATION ***These symptoms include difficulties modulating or expressing emotions, intense fear or helplessness, difficulties regulating sleep/wake cycle, and inability to fully engage in activities. This can include difficulties modulating or expressing emotions and energy states such as emotional outbursts or marked shifts in emotions, overly constricted emotional responses, and intense emotional responses, and/or evidence of constricted, hyperaroused, or quickly fluctuating energy level. The child may demonstrate such difficulties with a single type or a wide range of emotions and energy states. This can also include difficulties with regulation of body functions, including disturbances in sleeping, eating and elimination; over-reactivity or under-reactivity to touch and sounds; and physical or somatic complaints. This can also include difficulties with describing emotional or bodily states. The child's behavior likely reflects their difficulty with affective and physiological regulation, especially for younger children. This can be demonstrated as excessive and chronic silly behavior, excessive body movements, difficulties regulating sleep/wake cycle, and inability to fully engage in activities.***
0	Child has no problems with affect regulation.
1	Child has **mild** to moderate problems with affect regulation. This rating is given to a child with some minor and occasional difficulties with affect/physiological regulation. This child could have some difficulty tolerating intense emotions and become somewhat jumpy or irritable in response to emotionally charged stimuli, or more watchful or hypervigilant in general or have some difficulties with regulating body functions (e.g. sleeping, eating or elimination). This child may also have some difficulty sustaining involvement in activities for any length of time or have some physical or somatic complaints.
2	Child has **moderate** problems with affect /physiological regulation, but is able to control affect at times. Problems with affect regulation interfere with child's functioning in some life domains. This child may be unable to modulate emotional responses or have more persistent difficulties in regulating bodily functions. This child may exhibit marked shifts in emotional responses (e.g. from sadness to irritability to anxiety) or have contained emotions with a tendency to lose control of emotions at various points (e.g. normally restricted affect punctuated by outbursts of anger or sadness). This child may also exhibit persistent anxiety, intense fear or helplessness, lethargy/loss of motivation, or affective or physiological over-arousal or reactivity (e.g. silly behavior, loose active limbs) or underarousal (e.g. lack of movement and facial expressions, slowed walking and talking).
3	Child unable to regulate affect. This rating is given to a child with **severe** and chronic problems with highly dysregulated affective and /or physiological responses. This child may have more rapid shifts in mood and an inability to modulate emotional responses (feeling out of control of their emotions or lacking control over their movement as it relates to their emotional states). This child may also exhibit tightly contained emotions with intense outbursts under stress. Alternately, this child may be characterized by extreme lethargy, loss of motivation or drive, and no ability to concentrate or sustain engagement in activities (i.e. emotionally "shut down"). This child may have more persistent and severe difficulties regulating sleep/wake cycle, eating patterns or with elimination problems.

	RE-EXPERIENCING THE TRAUMA (Intrusions) ***These symptoms consist of intrusive memories or reminders of traumatic events, including nightmares, flashbacks, intense reliving of the events, and repetitive play with themes of specific traumatic experiences.***
0	**This rating is given to a child with** no evidence **of intrusive symptoms.**
1	**Child experiences some intrusive thoughts of trauma but they do not affect his/her functioning. For example, a child with** some problems with intrusive symptoms, distressing memories**, including occasional nightmares about traumatic events would be rated here.**
2	**This rating is given to a child with** moderate difficulties with intrusive symptoms/distressing memories**, intrusive thoughts that interfere in his/her ability to function in some, but not all life domains. For example, the child may have** recurrent frightening dreams **with or without recognizable content or recurrent distressing thoughts, images, perceptions or memories of traumatic events. The child may exhibit** trauma-specific reenactments **through** repetitive play **with themes of trauma or** intense physiological reactions **to exposure to** traumatic cues**.**
3	**This rating is given to a child with repeated and/or severe intrusive symptoms/distressing memories. This child may exhibit** trauma-specific reenactments that include sexually or physically traumatizing other children or sexual play **with adults. This child may also exhibit** persistent flashbacks, illusions or hallucinations **that make it** difficult for the child to function**.**

	AVOIDANCE ***These symptoms include efforts to avoid stimuli associated with traumatic experiences.***
0	This rating is given to a child with **no evidence** of avoidance symptoms.
1	This rating is given to a child who exhibits **some avoidance**. The child may experience **one primary avoidant symptom**, including efforts to **avoid thoughts, feelings, or conversations associated with the trauma.**
2	This rating is given to a child with **moderate symptoms of avoidance**. In addition to avoiding thoughts or feelings associated with the trauma, the child may also **avoid activities, places, or people** that arouse recollections of the trauma.
3	This rating is given to a child who exhibits **significant or multiple avoidant symptoms**. This child may **avoid thoughts and feelings as well as situations and people** associated with the trauma and **be unable to recall important aspects of the trauma**.

	INCREASED AROUSAL ***These symptoms include difficulty falling or staying asleep, irritability or outbursts or anger, difficulty concentrating, hypervigilance and/or exaggerated startle response. Children may also manifest physical symptoms such as stomach-aches and headaches.***
0	There is **no evidence** of increased arousal.
1	This rating is given to a child who exhibits **mild hyperarousal** that does not significantly interfere with his or her day-to-day functioning. Children may also occasionally manifest physical symptoms such as stomach-aches or headaches.
2	This rating is given to a child which **moderate symptoms** of hyperarousal or alternations in arousal and reactivity associated with traumatic event(s). Infants appear wide eyed, over reactive to stimuli, and have an exaggerated startle response. The child may exhibit **one significant symptom or a combination of two or more** of the following symptoms: difficulty falling or staying asleep, irritability or outbursts of anger, difficulty concentrating, hypervigilance and/or exaggerated startle response. Children may commonly have physical symptoms such as stomach-aches or headaches. .
3	This rating is given to a child who exhibits **multipl**e and**/**or **severe hyperarousal symptoms** including alternations in arousal and reactivity associated with traumatic event(s). These may include symptoms listed above; the **intensity or frequency of these symptoms is distressing for the child and leads to frequent problems with day-to-day functioning**.

	NUMBING OF RESPONSIVENESS ***These symptoms include numbing responses which were not present before the trauma experience(s)***
0	There is **no evidence** of numbing of responsiveness.
1	This rating is given to a child who exhibits **some** problems with numbing. This infant or child may have a restricted range of affect or be **unable to express or experience certain emotions** (e.g. anger or sadness.)
2	This rating is given to a child with **moderately severe numbing** responses. This child may have a **blunted or flat emotional state** or have **difficulty experiencing intense emotions** or feel **consistently detached** or **estranged** from others following the traumatic experience. Infants and toddlers may appear emotionally subdued, socially withdrawn and constricted in their play. Older children may exhibit all of the same symptoms as well as less spontaneous speech and peer interaction.
3	This rating is given to a child which **significant numbing responses** or **multiple symptoms of numbing**. This child may have a **markedly diminished interest** or participation in significant activities. Infant/child demonstrates numbing of responsiveness most of the time and this is impeding development.

	TRAUMATIC GRIEF AND SEPARATION This ***rating describes the level of traumatic grief the child is experiencing due to death or loss/separation from significant caregivers, siblings, or other significant figures.***
0	There is **no evidence** that the child is experiencing traumatic grief or separation from the loss of significant caregivers. Either the child has not experienced a traumatic loss (e.g. death of a loved one) or the child has adjusted well to separation.
1	Child is experiencing a **mild level** of traumatic grief due to death or loss/separation from a significant person in a manner that is expected and/or appropriate given the recent nature of loss or separation.
2	Child is experiencing a **moderate level** of traumatic grief or difficulties with separation in a manner that **impairs functioning in some but not all areas**. This could include withdrawal or isolation from others or other problems with day-to-day functioning.
3	Child is experiencing **significant traumatic grief reactions**. Child exhibits **impaired functioning across several areas** (e.g. interpersonal relationships, school) for a significant period of time following the loss or separation. **Symptoms require immediate or intensive intervention**.

REGULATORY FUNCTIONING MODULE

This module is intended to describe the dimensions of regulatory functioning.

	EATING ***This category refers to all dimensions of eating.***
0	There is no evidence of problems related to eating.
1	Mild problems with eating that have been present in the past or are currently present some of the time causing mild impairment in functioning.
2	Infant/child has moderate problems with eating are present and impair the child's functioning. Infants may be finicky eaters, spit food or overeats. Infants may have problems with oral motor control. Older children may overeat, have few food preferences and not have a clear pattern of when they eat.
3	Infant/child has severe problems with eating are present putting the infant/child at risk developmentally. The child and family are very distressed and unable to overcome problems in this area.

	ELIMINATION ***This category refers to all dimensions of elimination.***
0	There is no evidence of elimination problems.
1	Infant/child may have a history of elimination difficulties but is presently not experiencing this other than on rare occasion.
2	Infant/child demonstrates problems with elimination on a consistent basis. This is interfering with child's functioning. Infants may completely lack a routine in elimination and develop constipation as a result. Older children may experience the same issues as infants along with encopresis and enuresis.
3	Infant/child demonstrates significant difficulty with elimination to the extent that child/parent are in significant distress or interventions have failed.

	SENSORY REACTIVITY ***This rating describes the child's ability to use all senses including vision, hearing, smell, touch, taste, and kinesthetics.***
0	There is no evidence of sensory reactivity that is hyper or hypo reactive.
1	Infant/child may have a history of sensory issues or have mild issues currently that are controlled by caregiver support.
2	Infant/child demonstrates hyper/hypo reactivity to sensory input in one or more sensory modality such that impairment in functioning is present.
3	Infant/child demonstrates significant reactivity to sensory input such that caregiver cannot mediate the effects of such.

	EMOTIONAL CONTROL This ***rating describes the child's general mood state and ability to be soothed.***
0	Infant/child has no problems with emotional control.
1	Infant/child has mild problems with emotional control that can be overcome with caregiver support.
2	Infant/child has a moderate level of problems with emotional control that interferes most of the time with functioning. Infants may be difficult to console most of the time and do not respond well to caregiver support. Older children may quickly become frustrated and hit or bite others.
3	Infant/child has a significant level of emotional control problems that are interfering with development. Caregivers are not able to mediate the effects of this.